7/19/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Bayan(@alzoabi_bayan)* ***Case Discussants****: Rahul(@) & Lera(@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Brandy)

CC: 51 y/o F, presented w fever, night sweats and dry cough.

HPI:

3 weeks of subjective fevers, cough, runny nose, sneezing that lasted ~1 week. 3 days later, started having left-sided pleuritic chest pain and progressively worsening SOB.

ROS:

Fatigue, malaise, loss of appetite. Drenching night sweats. Orthopnea + trepopnea in the left lateral decubitus position over the past 3 days. Nausea, headache.

PMH:

T2DM

Meds:

Metformin
Dapagliflozin,
non-compliant

Fam Hx:

Unremarkable

Social Hx:

ICU (Burn unit) nurse not sexually active, lives alone.

Health-Related Behaviors:

Smoker 1 pack/day for 15 years.

Allergies:

NKDA

Vitals: T:39.4C **HR**:127 **BP**: 93/60 (MAP 79) **RR**: 28 **Sat**: 84% **BMI**:

Exam: Gen: Ill appearing, sweating, in respiratory distress

CV: Tachycardic, normal S1 and S2. No additional heart sounds

Pulm: Diminished breath sounds, dullness to percussion over the left lung

Abd: Normal

Neuro: Alert and oriented x3. No focal neurological deficits.

Extremities/skin: No rashes. No LL edema, capillary refill time >2s

Notable Labs & Imaging:

Hematology:

WBC: 25.5 (Neutrophil predominant) Hgb:9.8 Plt: 968 MCV:73

Chemistry:

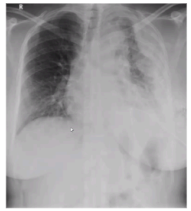
Na: K: Cl: HCO3: Cr: BUN: Glucose: Ca: Mg:

AST: ALT: Alk-P: Bili: Albumin: Total Protein:

ESR: CRP: 202 LDH:

HIV, HBV, HCV (-) UA: Glu (+)BCx X2 pending

HBA1C 10.6%



Pleural fluid analysis: turbid fluid, pH 7.08, LDH: 4500 U/L, Glucose 31, Protein 4.1, cell count 11,000 neutrophil predominant, TB PCR x2 (-)

AFB Sputum x3 (-)

Imaging:

EKG: HR 127, sinus rhythm

CXR:

CT Chest: large multiloculated left sided empyema with severe lung compression. Small right sided pleural effusion.

Echo: LVEF 65%, no structural or valvular abnormalities

Culture from pleural fluid grew Vancomycin-resistant Staph aureus

Dx VRSA pneumonia complicated by Empyema

Problem Representation:

51 y/o female, with history of uncontrolled diabetes presented with fever, night sweats, cough and left sided pleuritic chest pain.

Teaching Points (Noor)

Approach to Chief Complaint: Fever → think about inflammation.. Dry cough→ Lung involvement– IMADE - infection, malignancy, autoimmune, Drugs, Endocrinopathy.

***Night sweats→ a clue to subacute course. Left sided pleuritic chest pain→ most likely left sided lung involvement.**

***Who is the host? → Has T2DM, Smoking history→ more predisposed to infections. Healthcare worker—> High risk for TB.**

***Orthopnea—-> Obesity, COPD, HF. Trepopnea—> Left sided empyema? effusion.**

Approach to Vitals and Exam Findings:

***Sub acute pulmonary Syndrome with neutrophil predominant leukocytosis and thrombocytosis→ think about pyogenic abscess/ empyema. Ischemia should be in the DDx**

*** SIRS positive→ Give fluids. Chest tube, get pleuritic fluid studies**

***Consider CT scan to better visualize the lung and pleura**

***Pleural Fluid Analysis Plus Loculated Pleural Effusion on Ct scan: Gram positive- anaerobic coverage- Ampicillin-sulbactam. Always think about dental causes as a risk factor for Empyema.**

***Lemierre Syndrome: Bacterial throat infection→infected blood clots in internal jugular vein and septic emboli to lungs.**

***Our patient was started on Vancomycin, Pip/tazo→ not improving→changed to anidulafungin, meropenem and linezolid.**